

File

HEALTH AND HUMAN SERVICES
FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0193TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

9 8 — 0 0 5 A

2. STATE:

Vermont

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

January 1, 1998

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

See attached.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 4a to Attachment 2.6-A
See attached.Supplement 12 to Attachment 2.6-A
page 1

7. FEDERAL BUDGET IMPACT:

a. FFY 98 \$ - 0 -
b. FFY \$9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

See attached. (TA/98-5)

None

10. SUBJECT OF AMENDMENT:

Post-Eligibility Treatment of Income

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:Sec. of Admin
for Gov. office

Kathleen C. Hunt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Cornelius Hogan

14. TITLE:

Secretary, Agency of Human Services

15. DATE SUBMITTED:

3/31/98

16. RETURN TO:

Debbie Mercy
Planning & Evaluation
Department of Social Welfare
103 South Main Street
Waterbury, VT 05671-1201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

3/31/98

18. DATE APPROVED:

June 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1-1-98 and 2-1-99

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Ronald Preston

22. TITLE:

Associate Regional Administrator

23. REMARKS:

See letter dated June 11, 1998 from Preston to Hogan.

Supp 12 to Attachment 2.6-A, page 1

TA 1000 12A 98 605A

86 18 JUN

CIVIL DIVISION
JAN 10 1998

Revision: HCFA-PM-97-2
December 1997

ATTACHMENT 2.6-A
Page 4a
OMB No.:0938-0673

State: Vermont

Condition	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	<p>2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:</p> <p>Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.</p> <p>a. Aged, blind, disabled: Individuals \$ <u>45.00</u> Couples \$ <u>90.00</u></p> <p>For the following persons with greater need:</p> <p>Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p>b. AFDC related: Children \$ <u>45.00</u> Adults \$ <u>45.00</u></p> <p>For the following persons with greater need:</p> <p>Supplement 12 to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p>c. Individual under age 21 covered in the plan as specified in Item B. 7. of <u>Attachment 2.2 -A</u>. \$ <u>45.00</u></p>

TN No. 98-5A
Supersedes
TN No. 98-5A

98-5

Approval Date 06-06-01

Effective Date 11/99 2/1/99

1/99
1/99